

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8711336
REG. NO.FOR
1- STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME FIRST MIDDLE LAST George W. Ahtes 27-87 GEORGE W. AHTEs | | 2a. DATE OF DEATH MONTH DAY YEAR 4/21/87 | | 2b. HOUR 5:30A | |
| 3. SEX Male MALE | 4. RACE White W. | 5. DATE OF BIRTH MONTH DAY YEAR 02 22 07 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia, Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CAMBRIDGE, MD DORCHESTER, MD | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building Superintendent | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE W. Main Street 21801 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Ahtes | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Mary (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 185-09-3841 | | 17. INFORMANT ADDRESS Mr. William J. Ahtes (Nephew) 1114 Riverside Drive, Salisbury, Md. 21801 | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardio-Respiratory Arrest
Possible acute MIAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Senile Dementia, COPD

| | | | |
|---|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE E. Tanman | | DEGREE MD | 22c. DATE SIGNED 4-21-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. E. TANMAN | | 22e. ADDRESS 17 FRANKLIN STR. CAMBRIDGE Md 21613 | |

| | | | |
|---|------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4/24/1987 | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Pk | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland |
| 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland HOLLOWAY FUNERAL HOME SALISBURY MD. | | 25a. DATE REC'D. BY REGISTRAR APR 24 1987 | 25b. REGISTRAR'S SIGNATURE Julia Tindem-Rubio |

BP

051524

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

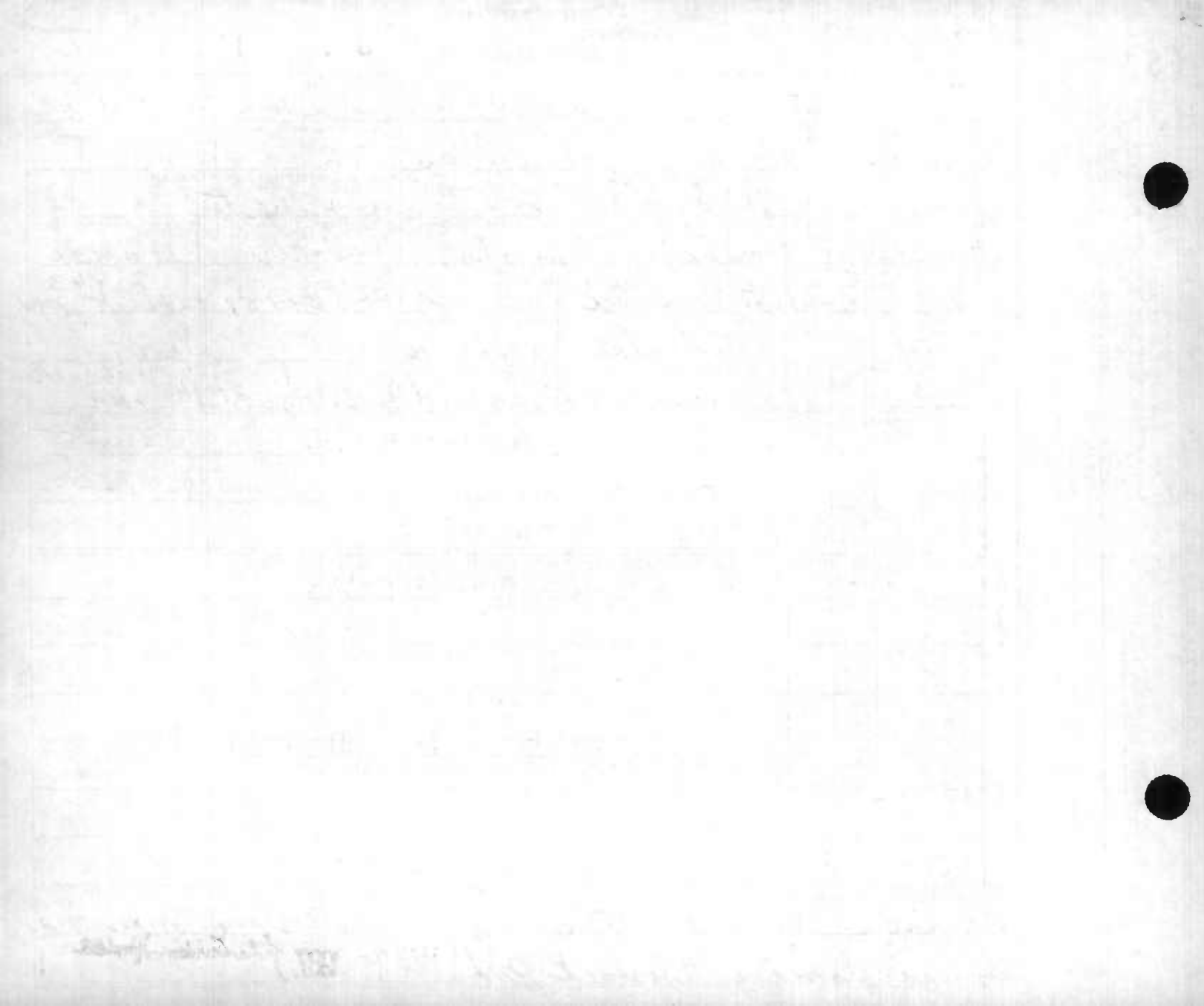
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8711337

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | April 29 1987 | | 11 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | 9 14 1915 | | 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S. | | Dorchester | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cambridge | | Dorchester General | | Laborer | | House | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | Dorchester | | Hurlock | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Fred | | Myra | | no | | 186-12-1045 | |
| 17. INFORMANT | | ADDRESS | | 17a. STREET ADDRESS / ZIP CODE | | 17b. CITY OR TOWN | |
| Gerald Aldridge | | Rt. 1 Box 51 Hurlock, Md. | | 21643 | | Hurlock | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Cerebral hemorrhage | | 12 hours | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | (b) Hypertension | | 20 years. | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | (c) Diabetes mellitus | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| Pneumonia, Chronic myocarditis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1978, to April 29, 1987, that (I) (we) last saw the deceased alive on April 29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Carlos F. Barroso MD | | MD. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Carlos F. Barroso MD | | Hurlock Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5-4-87 | | Petersburg | | Petersburg Dorchester Md. | |
| 24. NAME OF FUNERAL DIRECTOR | | 24b. ADDRESS | | 25. DATE REC'D. BY REGISTRAR (REG. NO. AND SIGNATURE) | | | |
| Bessie Smith | | Hurlock, Md. | | MAY 7 - 1987 | | | |



52101 MAY -1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

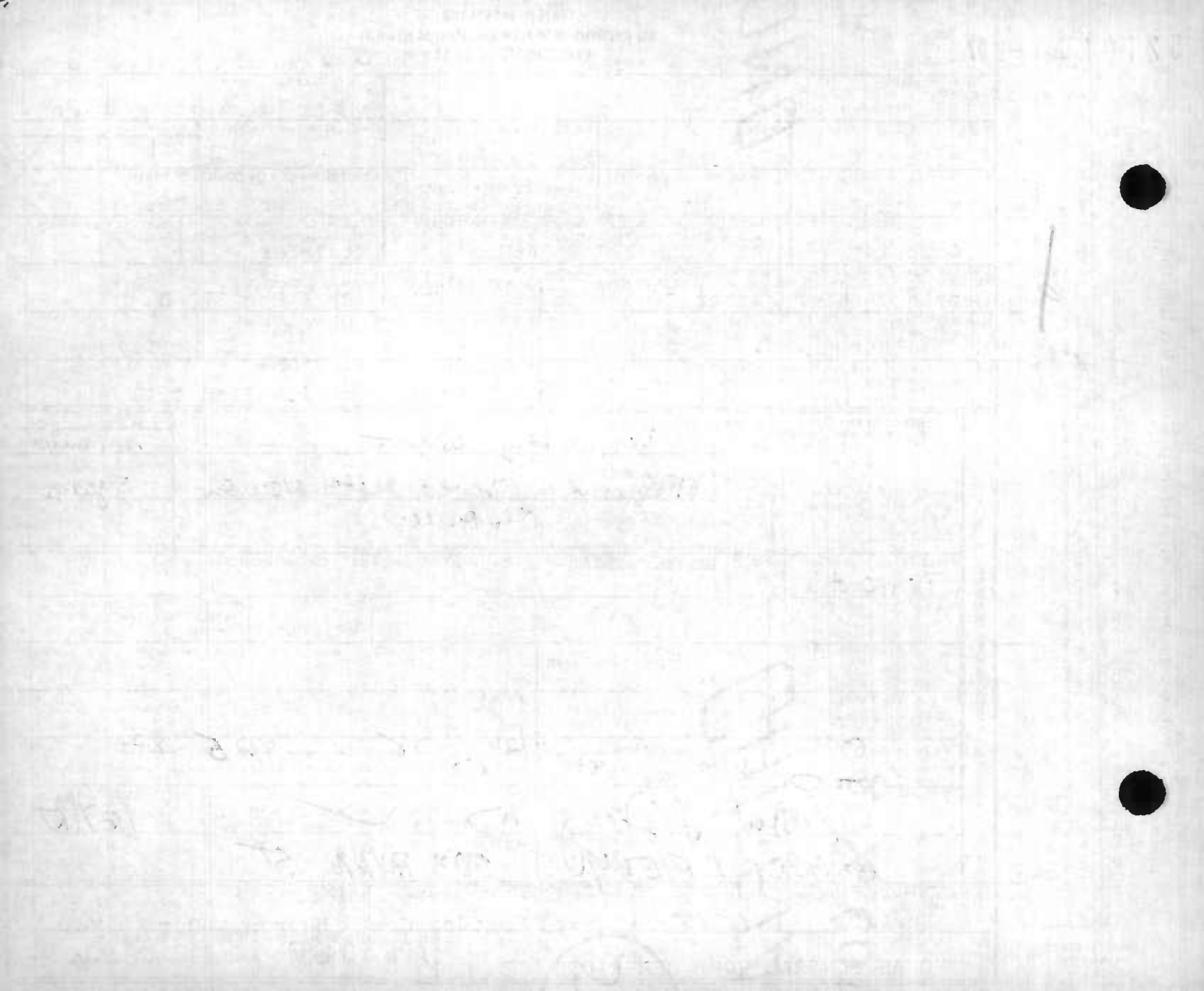
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11338

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Walter Lee Beckwith | | | 2a. DATE OF DEATH MONTH DAY YEAR April 25, 1987 | | 2b. HOUR 6:40 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug 29, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 3 Box 278 B (AtHome) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Beckwith | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Willey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-16-7037 | | 17. INFORMANT ADDRESS Goldie R. Beckwith Item # 13 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Progressive and Severe Motor Neuron</u> DUE TO, OR AS A CONSEQUENCE OF <u>disorder</u> (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Dementia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> 19 <u>78</u> to <u>4/25</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>4/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Hubert L. Gery</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>4/27/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. GERY</u> | | 22e. ADDRESS <u>503 BYRN ST</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/28/87 | 23c. NAME OF CEMETERY OR CREMATORY Seward Spedden Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hudson, Dor. Md. |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD. | | 25a. DATE REC'D. BY REGISTRAR APR 30 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 3 9

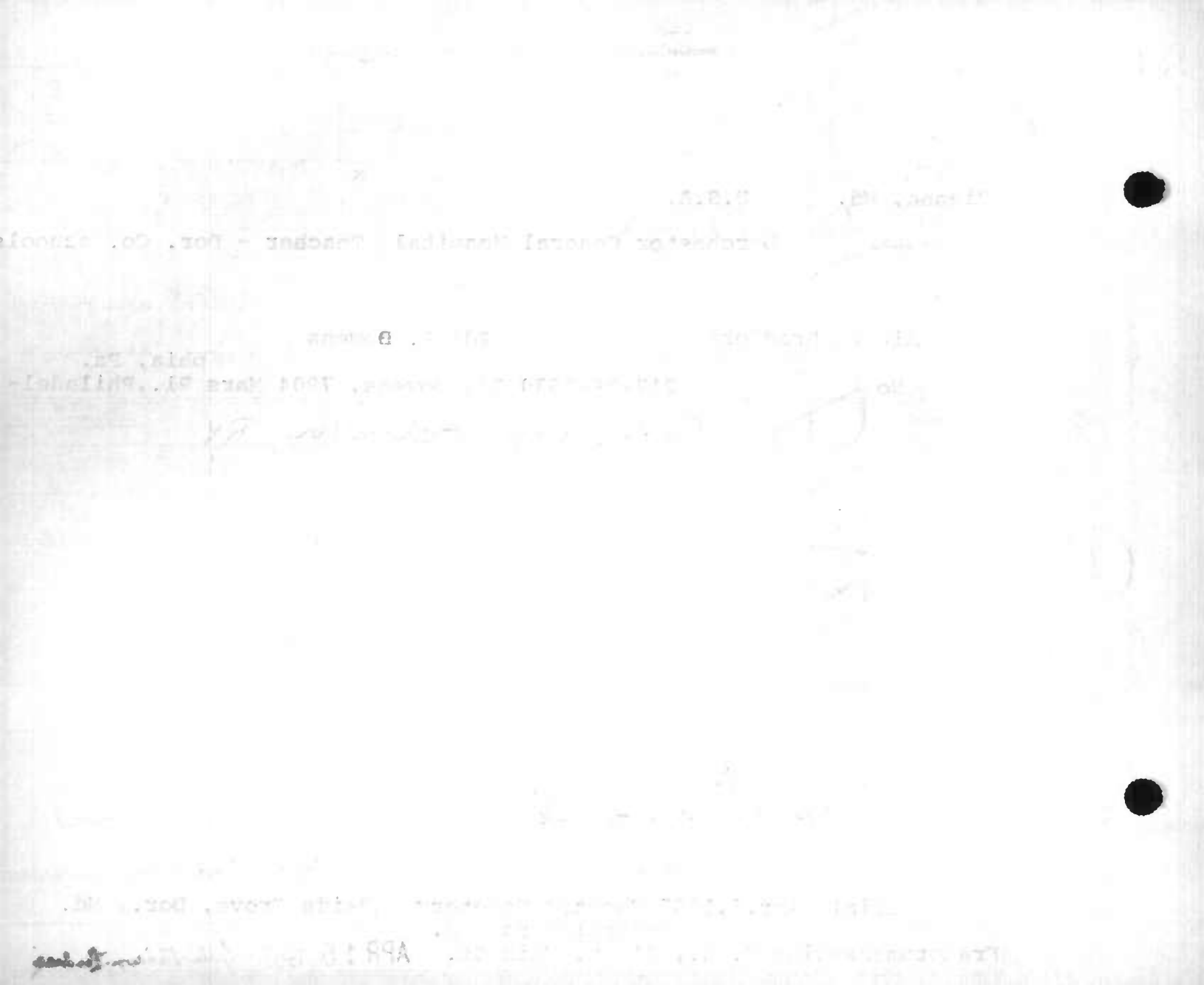
1- FOR
STATE
REGISTRAR

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Effie L. Bradford | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH 4 DAY 2 YEAR 87 19 | | 2b. HOUR 2100 |
| 3. SEX female | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 6-13-32 | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna, Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher - Dor. Co. schools | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE Md. | 13b. COUNTY Dor. | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 748 Cornish Drive 21613 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Bradford | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida A. Bowens | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-28-3530 | | 17. INFORMANT Ida Bowens, 7904 Mars Pl., Philadel- phia, Pa. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, Rx</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <u>Peter W. Rieckert</u> | | TITLE (SPECIFY) M.D. Dep. | | DATE SIGNED 4-3-87 |
| EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | ADDRESS East New Market, Md. 21631 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Apr. 6, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Reids Grove, Dor., Md. | |
| 24. FUNERAL DIRECTOR NAME Frampton-Hawkins F. H. | | ADDRESS Federalburg, Md. 21631 | | DATE REC'D. BY REGISTRAR APR 15 1987 |
| | | 25. REGISTRAR'S SIGNATURE Julia Davidson-Rubing | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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APR 18 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11340

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| FIRST MIDDLE LAST BERNICE BRYAN. | | Female | | Black | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| MONTH DAY YEAR 6/29/29 | | 57 YRS | | Md. | |
| 8. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| U.S. | | Dorchester MD. | | Cambridge | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Dorchester Gen Hospital | | Retired | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | Dorchester | | Cambridge | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Rosevelt Coleman | | Pearl Randall | | 16b. SOCIAL SECURITY NO. 215-20-1623 | |
| 17a. INFORMANT | | ADDRESS | | 17b. DATE OF OPERATION | |
| Dorothy Gaylon | | 716 Moores Ave Md. | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) Diase M.I.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22b. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22c. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22d. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22e. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22f. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22g. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22h. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22i. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22j. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22k. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22l. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22m. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22n. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22o. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22p. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22q. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22r. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22s. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22t. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22u. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22v. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22w. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22x. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22y. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22z. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22aa. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ab. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ac. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ad. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ae. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22af. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ag. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ah. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ai. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22aj. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ak. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22al. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22am. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22an. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ao. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ap. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22aq. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ar. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22as. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22at. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22au. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22av. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22aw. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ax. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ay. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22az. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ba. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bb. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bc. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bd. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22be. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bf. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bg. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bh. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bi. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bj. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bk. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bl. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bm. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bn. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bo. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bp. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bq. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22br. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bs. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bt. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bu. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bv. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bw. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bx. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22by. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22bz. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ca. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cb. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cc. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cd. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ce. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cf. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cg. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ch. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ci. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cj. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ck. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cl. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cm. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cn. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22co. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cp. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cq. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cr. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cs. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ct. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cu. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cv. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cw. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cx. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cy. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22cz. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22da. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22db. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dc. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dd. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22de. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22df. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dg. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dh. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22di. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dj. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dk. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dl. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dm. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dn. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22do. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dp. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dq. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dr. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22ds. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dt. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22du. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dv. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dw. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | to | | 4/18, 1987 | |
| 22dx. I certify that (I) (this hospital) attended the deceased from | | 4/15, 1987 | | | | | |

4/21

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 11341
REG. NO.

1- FOR
STATE
REGISTRAR

51084 APR 20 1987

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARYSIE M CANNON | | | 2a. DATE OF DEATH MONTH DAY YEAR 4 17 87 | | | 2b. HOUR 8:35 PM | | | |
| 3. SEX F | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DG Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Easton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 320 August Street 21601 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wilard Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Donavan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-6750 | | 17. INFORMANT ADDRESS Ann M. Smith 313 August St Easton MD 21601 | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **CMD, OBS, advancing age**

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/17 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/17 1987 to 4/17 1987 , that (I) (we) last saw the deceased alive on 4/17 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Hubert L. Ferry | | | | DEGREE M ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. FERRY | | | | 22e. ADDRESS 503 BYRN ST | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR APR 21 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

052555 MAY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

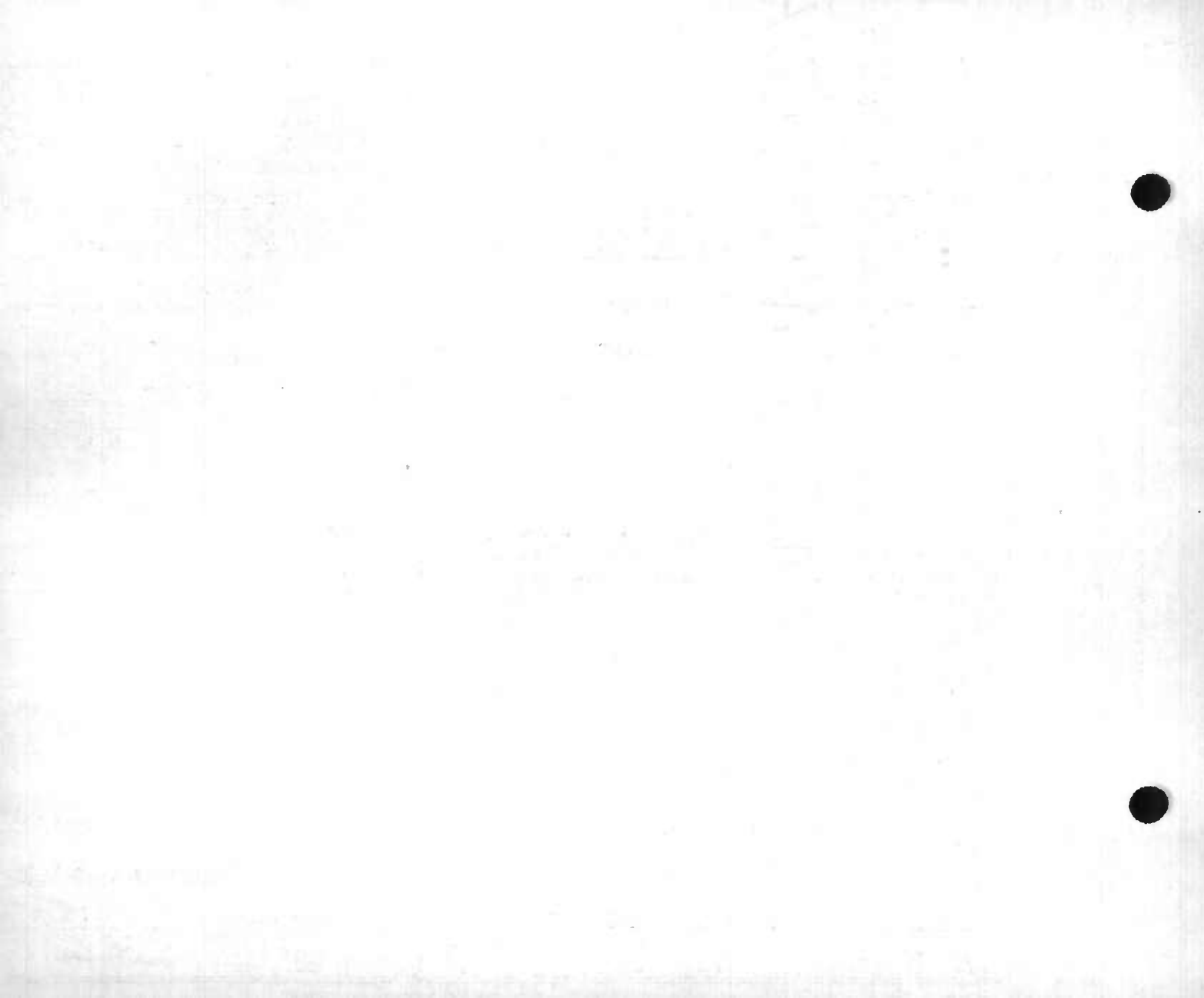
BP _____

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 342 | |
| 1. DECEASED NAME (TYPE OR PRINT) LEON M. CHESTER, JR | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 4 DAY 24 YEAR 87 | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 3 DAY 28 YEAR 41 | 6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY Seafood |
| 13a. STATE Maryland | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Church Creek | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST Leon MIDDLE Chester, Sr. LAST Irene | 15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE Meekins LAST Meekins | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 213-42-1021 | | 17. INFORMANT ADDRESS Irene Chester Box 669 Church Creek, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) HYPOTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE & CHRONIC LIVER FAILURE | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS HOURS YEARS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ALCOHOLISM, CHRONIC PANCREATITIS; CIRRHOSIS OF LIVER, MASSIVE ORGAN FAILURE TERMINALLY | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James F. McEster | | TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) JAMES F. MCESTER | | DATE SIGNED 4-30-87 | |
| ADDRESS 406 AURORA ST., CAMBRIDGE, MD. 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4-28-87 | 23c. NAME OF CEMETERY OR CREMATORY Meekins Neck Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Church Creek DOR MD |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home ADDRESS 510 Washington St. Cambridge Md. | 25a. DATE REC'D. BY REGISTRAR MAY 5 1987 | 25b. REGISTRAR'S SIGNATURE Julia Seiden-Rendall | |

21612



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **3 4 3**

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|---|--|---|---|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST TIMOTHY | | MIDDLE JOSEPH | | LAST D'ADAMO | | 20. DATE OF DEATH KNOWN <input type="checkbox"/> ESTI- MATED <input checked="" type="checkbox"/> | | MONTH 4 | | DAY 20 | | YEAR 87 | | 2b HOUR 1600 | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH 10 DAY 22 YEAR 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 4 21 1987 | | 2d HOUR 400 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER | | | | 12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN HURLOCK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS SUICIDE BRIDGE ROAD/21643 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST PHILIP MIDDLE G. LAST D'ADAMO | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST ELEANOR MIDDLE TUBMAN LAST TUBMAN | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | | | 17. INFORMANT ADDRESS RUTHANNA D'ADAMO, HURLOCK, MD | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Peter W. Rieckert</i> | | | | TITLE (SPECIFY) Dep. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 4-23-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | | | ADDRESS East New Market, Md. 21631 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 4-24-87 | | | | 23c. NAME OF CEMETERY OR CREMATORY OUR LADY OF GOOD COUNSEL | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SECRETARY, DORCHESTER, MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 30 1987 | | | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 3, WITHIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

100% POLYESTER

NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 87 11344 | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sarah Elizabeth Derby | | | | 2a. DATE OF DEATH MONTH DAY YEAR April 14, 1987 | | | | 2b. HOUR 2:30AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct 17, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 1 Box 331 (At Home) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt 1 Box 331 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luther | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Wroten | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 215-20-1113 | | 17. INFORMANT ADDRESS Clara Mace Brannock 1028 Washington Cambridge, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA</u> <u>Bowel</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> 19 <u>85</u> to <u>APRIL</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> M.D. | | | | DEGREE | | | | 22c. DATE SIGNED <u>4/15/87</u> | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H E Anderson</u> | | | | 22e. ADDRESS <u>408 BYRN ST CAMBRIDGE MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY E. New Mkt Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE E. New Mkt Dor Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | | ADDRESS CAMBRIDGE, MD. | | 25a. DATE REC'D BY REGISTRAR APR 20 1987 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

BP _____

98112

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

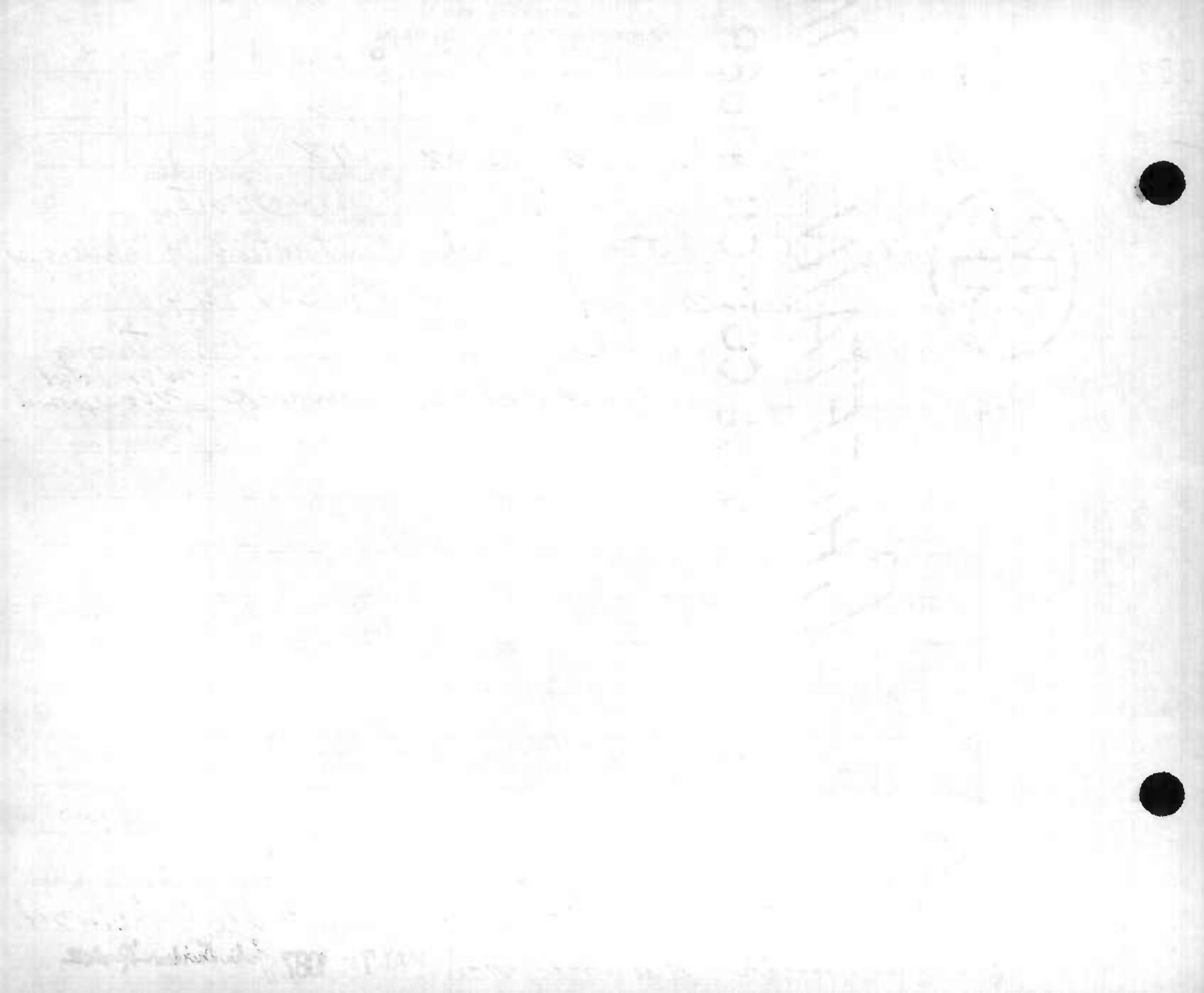
REG. NO.

87 11345

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Joseph W Dunnock</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>4/26/87</i> | | | 2b. HOUR M | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 12 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Cambridge</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK IN MOST OF WORKING LIFE) <i>Construction</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Highways</i> | |
| 13a. STATE <i>MD.</i> | | | 13b. COUNTY <i>Dorchester</i> | | 13c. CITY OR TOWN <i>Woolford</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Dunnock</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Ann Armstrong</i> | | | 16. STREET ADDRESS / ZIP CODE <i>P.O. Box 144 21617</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>unknown</i> | | 17. INFORMANT NAME ADDRESS <i>Nellie Dunnock Woolford Maryland</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diffuse carcinoma of abdomen</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/24</i> , 19 <i>87</i> , to <i>4/26</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>4/26</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>David B. Stoeckle MD</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>4/26/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID B. STOECKLE MD</i> | | | | | | 22e. ADDRESS <i>209 MARYLAND AVE CAMBRIDGE, MD 21613</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>5-2-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Smithville</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smithville Dorchester MD</i> | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Bessie Smith Harlock, Md.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 7 - 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | |

MEDICAL CERTIFICATION



050841 APR 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 11346
REG. NO.

| | | | | | |
|--|---|--|--|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) ALMA JONES MOORE ERDMAN <i>ALMA ERDMAN</i> | | | 2a DATE OF DEATH MONTH DAY YEAR 4 12 87 | | 2b HOUR 8:30 AM |
| 3 SEX FEMALE | 4 RACE CAU. | 5 DATE OF BIRTH MONTH DAY YEAR March 31, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | |
| 10 CITY OR TOWN OF DEATH CAMBRIDGE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS | 12b KIND OF BUSINESS OR INDUSTRY GARMENT | |
| 13a STATE MARYLAND | | | 13b COUNTY DORCHESTER | | |
| 13c CITY OR TOWN CAMBRIDGE | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST FRANK H. JONES | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE INSLEY | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b SOCIAL SECURITY NO. 212-104565 | | |
| 17 INFORMANT Granddaughter | | | ADDRESS Columbia, Md. 21046 | | |
| 17b Gwen Weathington | | | ADDRESS 8818 Stonebrook Ln. | | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | |
|---|---|--|--|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (1) (this hospital) attended the deceased from 4/14 19 87 to 4/12 19 87 that (1) (we) last saw the deceased alive on 4/12 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE <i>Maylann D. Moore MD</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED 4/12/87 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Maylann D. Moore | | 22e ADDRESS 404 BYRNST. CAMBRIDGE, MD | |

| | | | |
|---|----------------------------|---|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | 23b DATE 4/14/87 | 23c NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk. | 23d LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dor., Md. |
| 24 FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME, 308 High St. 21613 | | 25a DATE REC'D. BY REGISTRAR APR 20 1987 | 25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The State requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DATE: 11/11/04

TIME: 10:00

NAME: [illegible]



FILE NO: [illegible]

[Faint, illegible text, possibly a list or notes, occupying the left side of the page.]

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 341

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | William L. Green | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | 7. DATE PRONOUNCED DEAD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dansville, VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cambridge | | 10. CITY OR TOWN OF DEATH Cambridge | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 15. CITY OR TOWN OF DEATH Cambridge | |
| 16a. STATE Md. | | 16b. COUNTY Dor. | | 16c. CITY OR TOWN Cambridge | | 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS 913 Hubbard Street | |
| 17. FATHER'S NAME FIRST William | | 17. MOTHER'S MAIDEN NAME FIRST Lillian | | 18. FATHER'S NAME MIDDLE Green | | 18. MOTHER'S MAIDEN NAME MIDDLE Green | | 19. FATHER'S NAME LAST Green | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 19b. SOCIAL SECURITY NO. 237-24-5070 | | 19c. ADDRESS Sarah Wright 565 Greenwood Ave. | | 20. DATE OF OPERATION | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ | | 22. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | 23. DATE OF OPERATION | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 24. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 26. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 26. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 28. ACTUAL SIGNATURE Peter W. Rieckert, M. D. | | 28. TITLE (SPECIFY) M.D. Dep. | | 28. MEDICAL EXAMINER | | 28. DATE SIGNED 4-21-87 | |
| 29. EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | 29. ADDRESS East New Market, Md. 21631 | | 30. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 30. DATE 4-25-87 | | 30. NAME OF CEMETERY OR CREMATORY Union Chapel Ceme | |
| 31. FUNERAL DIRECTOR NAME Stewart Funeral Home | | 31. ADDRESS 510 Washington Street Cambridge, Md. 21613 | | 32. DATE REC'D. BY REGISTRAR MAY 5 1987 | | 32. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | 33. LOCATION CITY OR TOWN Dorchester | |
| 34. STATE Md. | | 34. COUNTY Dorchester | | 34. CITY OR TOWN Cambridge | | 34. STATE Md. | | 34. COUNTY Dorchester | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WASHINGTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 1348

FOR
1. STATE
REGISTRAR

| | | | | |
|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Claude S. GREEVE | | 2a. DATE OF DEATH MONTH 4 DAY 9 YEAR 87 | | 2b. HOUR 630AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 3 DAY 3 YEAR 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U. S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENTIAL ADDRESS) 13b. STATE 2nd Dorchester | 13c. CITY OR TOWN Boston | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS R. 7 D. 1 Preston, Md. | |
| 14. FATHER'S NAME FIRST unknown MIDDLE unknown LAST unknown | 15. MOTHER'S MAIDEN NAME FIRST unknown MIDDLE unknown LAST unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) no | |
| 17a. SOCIAL SECURITY NO. 422-14-058 | | 17. INFORMANT Alice Wongus Cambridge, Md. ADDRESS 700 Hight St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c): | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): D. Mellitus, Multi-infarct Dementia, Periph. Vasc. Dis. H. Tension | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE G. Conway | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4-16-87 | 23c. NAME OF CEMETERY OR CREMATORY Cokesbury | 23d. LOCATION CITY OR TOWN COUNTY STATE | 25a. REGISTRAR'S SIGNATURE Julia Davidson-Randall |
| 24. FUNERAL DIRECTOR NAME Bessie Smith Hamlock, 2nd | | 25b. DATE REC'D. BY REGISTRAR APR 14 1987 | | 25c. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

APR 14 1987

4/20

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-instruction permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified.

BP

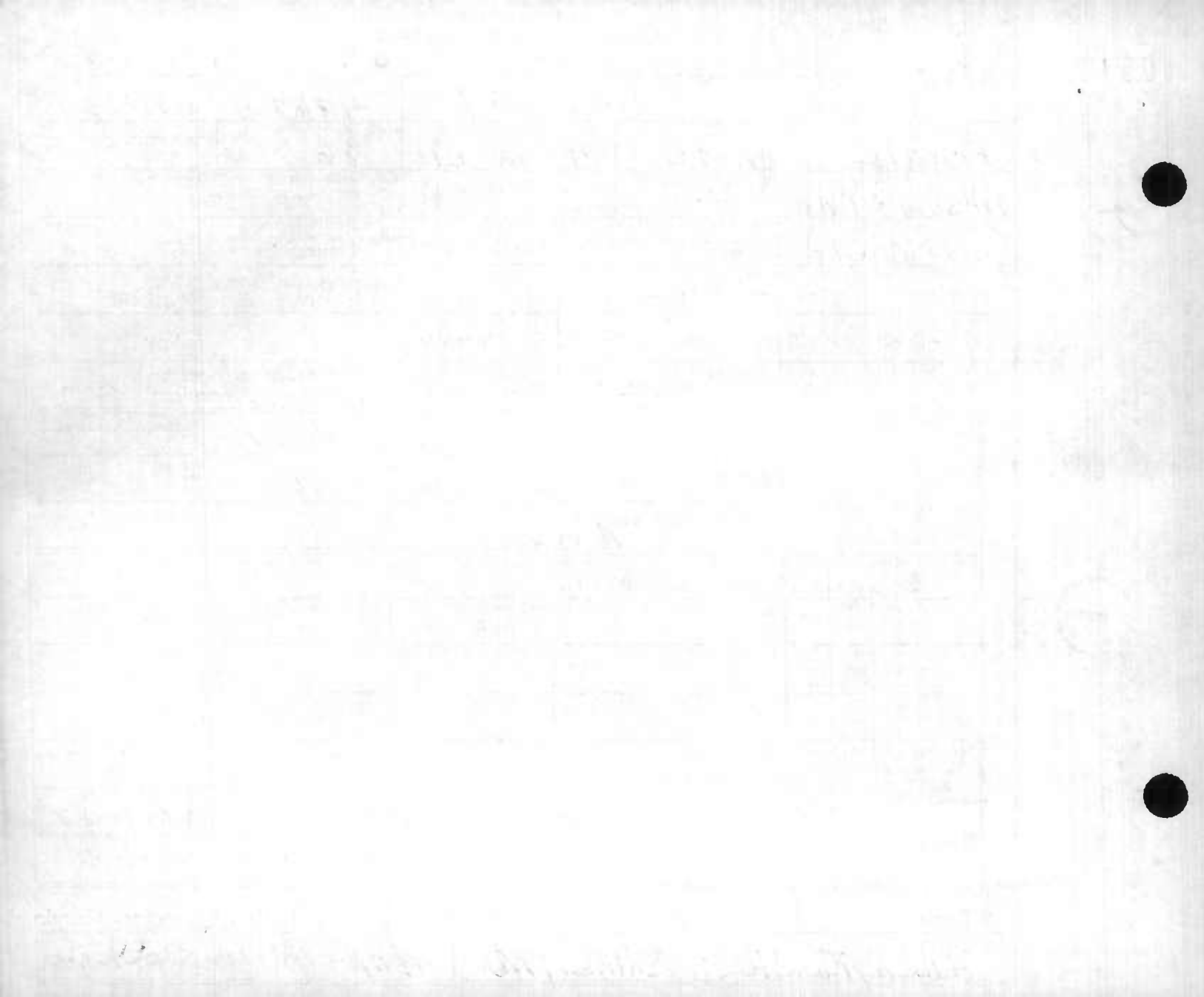
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11349

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Wilsie Holloway | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4/18/87 4 18 87 | | | | 2b. HOUR 2:30 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 12 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsville Md | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | |
| 10. CITY OR TOWN OF DEATH Cambridge Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Pittsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Old Ocean City Rd., 21850 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Manlius King Morris | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cordelia Bailey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-56-1185 | | 17. INFORMANT Mr. J. Morris Jones (Nephew) Route #6 Box 80, Salisbury, Maryland 21801 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Poor general condition DUE TO, OR AS A CONSEQUENCE OF (c) A SCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Organic Brain Syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD | | | | 22c. DATE SIGNED 4-18-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] | | | | 22e. ADDRESS Cambridge House, Cambridge, Md. 21613 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 04/18/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Powellville Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Powellville, Wicomico, Maryland | | | |
| 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland Holloway Funeral Home Salisbury Md. | | | | 25a. DATE REC'D. BY REGISTRAR 4 APR 27 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to interment, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 11350
REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) David M. Hungerford, Sr. | | | 2a. DATE OF DEATH MONTH 4 DAY 22 YEAR 87 | | 2b. HOUR 4³⁰ A.M. |
| 3. SEX Male | 4. RACE WHITE | 5. DATE OF BIRTH MONTH April DAY 15 YEAR 1905 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House/Genesis | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY PURIFICATION WATER |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY DORCHESTER 13c. CITY OR TOWN CAMBRIDGE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST Churchill MIDDLE LAST Hungerford, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Meck | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 146-10-9684 | 17. INFORMANT ADDRESS Mrs. Helvi Hungerford, Same as #13 | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Transitional cell CA urinary bladder | | |

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1987 to April 22, 1987 , that (I have) lost saw the deceased alive on Apr 21, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I have) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Lewis M. Burdette MD | | DEGREE MD | 22c. DATE SIGNED Apr 22, 1987 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette | | 22e. ADDRESS 4 Aurora St Cambridge Md 21613 | |

| | | | |
|--|--------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | 23b. DATE 4--25-1987 | 23c. NAME OF CEMETERY OR CREMATORY Pine Crest Cemetery | 23d. LOCATION CITY OR TOWN Lake Worth COUNTY Palm Beach STATE FL |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home ADDRESS 308 High St. Cambridge, Md. | | 25a. DATE REC'D. BY REGISTRAR APR 24 1987 | 25b. REGISTRAR'S SIGNATURE Lewis M. Burdette |

21295



Handwritten text, likely a title or description, possibly mentioning "The ... of ...".

18 - 21

Handwritten text at the bottom of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 and any injury, or other traumatic event, the medical examiner may be notified.

Item 13 per phone

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11351

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD DEAN INSLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 4-14-1987 | | 2b. HOUR 24 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 6-7-1925 | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL | | 12a. USUAL OCCUPATION (TIME OF WORK FOR MOST OF WORKING LIFE) Poultry Grower | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. CITY OR TOWN Nanticoke | 13c. STREET ADDRESS / ZIP CODE Rural 21840 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William R. Insley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Maxie Anderson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 2 215-20-1925 | 17. INFORMANT ADDRESS Esther L. Insley, Nanticoke, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior Myocardial Infarction. 72 hrs. DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY HEART DISEASE 6 yrs. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC OBSTRUCTIVE PULMONARY DISEASE - TOBACCO DEPENDENCE | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input checked="" type="checkbox"/> AT HOME | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4-10-19-87 to 4-14-19-87. (not (1) (two) lost saw the deceased alive on 4-13-19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE A. K. WILCE MD | | | | 22c. DATE SIGNED 4.14.87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. K. WILCE MD | | | | 22e. ADDRESS 200 MARYLAND AVENUE Cambridge MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY Bivalve, Bm. | |
| 24. FUNERAL DIRECTOR NAME Messick Funeral Home | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bivalve, MD | | 23e. DATE REC'D. BY REGISTRAR APR 20 1987 | |
| 25. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | | 25b. REGISTRAR'S SIGNATURE | |

RECEIVED
JAN 10 1902
NEW YORK



[Faint, mostly illegible handwritten text, possibly a letter or memorandum.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11352

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Ervin</u> <u>Carl Knauer, Sr.</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>April 3 87</u> | | 2b. HOUR <u>11:30 A.M.</u> | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>June 15, 1899</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>87</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Kansas</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>US</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester Co.</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Cambridge</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Maryland</u> | | | | 13c. CITY OR TOWN <u>Dorchester Cambridge</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>August F. Knauer</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret Foessler</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>217-36-0780</u> | | 17. INFORMANT ADDRESS <u>Elnora M. Knauer Item # 13</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>888</u> IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial ischemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>three days</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Fracture of right hip Chronic Dementia</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>4/2/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture of right hip</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR <u>5:30 P.M. 3-31 87</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Fell at home</u> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>home</u> | | 21f. LOCATION CITY OR TOWN COUNTY STATE <u>Rt 2 Box 386 Cambridge Dor Md</u> | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>March 31</u> , 19 <u>86</u> , to <u>April 3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>April 3</u> , 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Edmund J MacLaughlin</u> | | | | DEGREE <u>ATTENDING PHYSICIAN</u> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>4/3/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edmund J MacLaughlin</u> | | | | 22e. ADDRESS <u>10 Aurora St. Cambridge Md 21613</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>4/6/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial park</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cambridge, Dor. Md.</u> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>THOMAS FUNERAL HOME CAMBRIDGE, MD.</u> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>APR 7 1987</u> <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-paper pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 (worked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.)

55019-1401100-802

105

11/15/2014

(210)

050840 APR 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 11353
REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph CHESTER KOLAREK | | 2a. DATE OF DEATH MONTH DAY YEAR 4 11 87 | | 2b. HOUR 1:45 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 18 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 71 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | |
| 10. CITY OR TOWN OF DEATH Cambridge, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN TAYLOR'S ISL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH KOLAREK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES LUZA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 212-01-7048 | | 17. INFORMANT WIFE ADDRESS FRANCES KOLAREK SAME AS #13 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastatic Oat Cell Carcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

Several months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-9 , 19 87 , to 4-11 , 19 87 , that (I) (we) last saw the deceased alive on 4-10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edmund J. MacLaughlin | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin | | | | 22e. ADDRESS 10 Aurora St. Cambridge House | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 04-15-87 | | 23c. NAME OF CEMETERY OR CREMATORY OLD TRINITY CH. GRVYD | | 23d. LOCATION CITY OR TOWN COUNTY CHURCH CREEK, DORCHESTER MD. | |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR APR 20 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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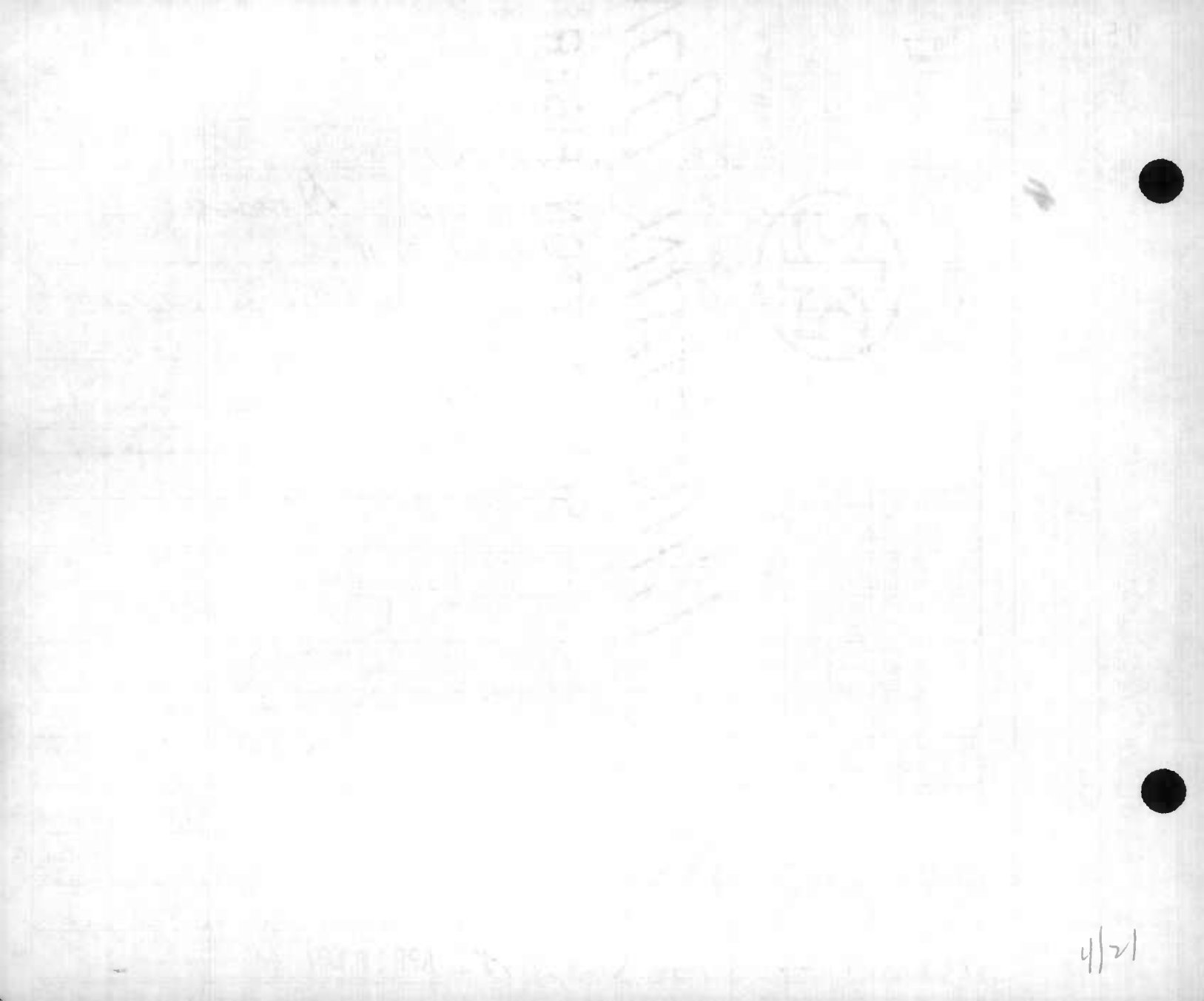
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 11354 | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN F. LEMON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4-14-87 | | | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 17 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Fields | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 217-10-8425 | | 17. INFORMANT ADDRESS Susan Hack 606 Chesapeake Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a SQUAMOUS CELL CARCINOMA OF ENDOMETRIUM | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — — — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 26 19 87 , to APRIL 14 19 87 , that (I) (we) lost saw the deceased alive on MARCH 14 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael A. Woskiewicz MD | | | | DEGREE MD | | 22c. DATE SIGNED 4-14-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. WOSKIEWICZ MD | | | | 22e. ADDRESS 503 BYEW ST CAMBRIDGE MD. 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel Ceme. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Stewart Funeral Home Cambridge Md | | | | 25a. DATE REC'D. BY REGISTRAR APR 16 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | |



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be called in and the certificate signed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|---|--|---------------------------|--|---|--|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LUCY WRIGHT PARKER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4/21/87 | | 2b. HOUR 8:59 AM | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 25, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN HURLOCK | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST COLUMBUS WRIGHT | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VICTORIA WEBSTER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) - | | 17. INFORMANT P. O. BOX 180 BROOKS PARKER, HURLOCK, MD 21643 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Uro sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Pseudomonas obliterans Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Mild upper extremities | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19, 1982, to 4-21, 1982, that (I) (we) last saw the deceased alive on 4-20, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE Michael J. Fadden | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4-21-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. FADDEN, M.D. | | | | | | 22e. ADDRESS 302 COLLINS AVENUE, HURLOCK, MD 21643 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 4-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE EAST NEW MARKET, DORCHESTER, MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS ZELLER FUNERAL HOME, EAST NEW MARKET, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE John Fadden | | | |

MAY 5 1987

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50839 APR 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 356

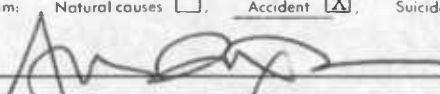
| | | | | | | |
|---|------------------------|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Terry Lee Phillips | | | 7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4/ 11/ 1987 | | | 2b. HOUR M 7:40 P M |
| 3 SEX MALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 11 27 1950 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/ 11/ 1987 | 7d. HOUR M 7:40 P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County, MD. |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER | |
| 13a. STATE MARYLAND | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN FISHINGCREEK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR ALBANUS PHILLIPS, SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA PARKS | | 17. INFORMANT FATHER , BOX 111 FISHING CRK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 216-56-1524 | | 17. INFORMANT A. ALBANUS PHILLIPS, SR. , MD. 21634 | | |


| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mechanical and Compression Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a:

| | | | | |
|--|--|---|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY MONTH DAY YEAR 7:00 P.M. 4/ 11/ 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/lost control/pinned in same |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. #16 North of Smithville Rd., Dorchester, Md |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE:  TITLE (SPECIFY) **M.D. Deputy Chief** MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) **Ann M. Dixon, M.D.** ADDRESS **111 Penn St.** DATE SIGNED **4/12/87**

| | | | |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 04-15-87 | 23c. NAME OF CEMETERY OR CREMATORY DORCH. MEM. PRK. CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE, DORCHESTER, MD. |
| 24. FUNERAL HOME NAME ADDRESS CURRAN FUNERAL HOME, 308 HIGH ST. CAMBRIDGE, MD. 21613 | | 25a. DATE REC'D. BY REGISTRAR APR 20 1987 | 25b. REGISTRAR'S SIGNATURE  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

OLIVIA LIBS

WINTER



051423 APR 24

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11357

| | | | | | | | | | | |
|--|--|---|---|---|---------------------------------------|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth E. Pritchett | | | 2a. DATE OF DEATH MONTH DAY YEAR April 17 87 | | | 2b. HOUR 10⁰⁵ AM | | | | |
| 3. SEX F | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 13 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 400 Cemetery Ave. 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Merritt E. PRITCHETT | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willmina Woodland | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-4232 | | 17. INFORMANT Ms. Alice B. Whitesel | | ADDRESS P. O. Box 25 Hurlock, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes five days five days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Insulin-dependent Diabetes; Hypertension; Chronic Obstructive Pulmonary Disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 13, 19 87 to April 17, 19 87 , that (I) (we) last saw the deceased alive on April 17, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Edmund J. MacLaughlin | | | | DEGREE MD | | | | 22c. DATE SIGNED 4/17/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin | | | | 22e. ADDRESS 10 Aurora St. Cambridge, Md 21613 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 4-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR APR 22 1987 | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | | | | | | |

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a signature or date, located in the center of the page.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 11358

FOR
STATE
REGISTRAR

| | | | |
|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) KEVIN Lee RIGGIN | | 2a. DATE OF DEATH MONTH DAY YEAR 4/11/87 9:27 AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 7, 1969 | 6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. |
| 10. CITY OR TOWN OF DEATH Hurlock | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 102 Gay Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE Maryland | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Hurlock | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Sidney Riggins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Diana Lee Hearn | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-60-0705 | 17. INFORMANT ADDRESS Robert S. Riggins Item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Edward Sytko | | DEGREE MD | 22c. DATE SIGNED 4/11/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Edward Sytko | | 22e. ADDRESS 408 BURN ST. CAMBRIDGE MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4/14/87 | 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Sussex Del. |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD. | | 25a. DATE REC'D. BY REGISTRAR APR 14 1987 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician who certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for the burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

4/16

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2025 COTTON 41825

2025 COTTON 41825

2025 COTTON 41825

50059 APR 10

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 REG. NO. 359

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GARFIELD REGINALD STANLEY | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4-4 19 87 | | 2b. HOUR 2:20 AM |
| 3. SEX male | 4. RACE B. | 5. DATE OF BIRTH MONTH 2 DAY 14 YEAR 49 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester county MD. |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Reginald Stanley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Wilson Stanley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 210-50-0986 | | 17. INFORMANT ADDRESS Stanley |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHXIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) VOMITING OF GASTRIC MATERIAL DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLIC INTOXICATION | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES MINUTES HOURS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE <i>James F. McCarter</i> | | TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER | | DATE SIGNED 4-6-87 |
| EXAMINER'S NAME (TYPE OR PRINT) James F. McCarter, M. D. | | ADDRESS 400 Aurora St., Cambridge, Md., 21613 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 4/9/87 | 23c. NAME OF CEMETERY OR CREMATORY Christ Ceme | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Stewart Funeral Home 2 Cambridge Md | | 25a. DATE REC'D. BY REGISTRAR APR 9 1987 | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

 BP _____
 DHMH - 17
 (VR A15 ME (5))
 15M 2/80

7

4/14

18000 0004

051484 APR 2

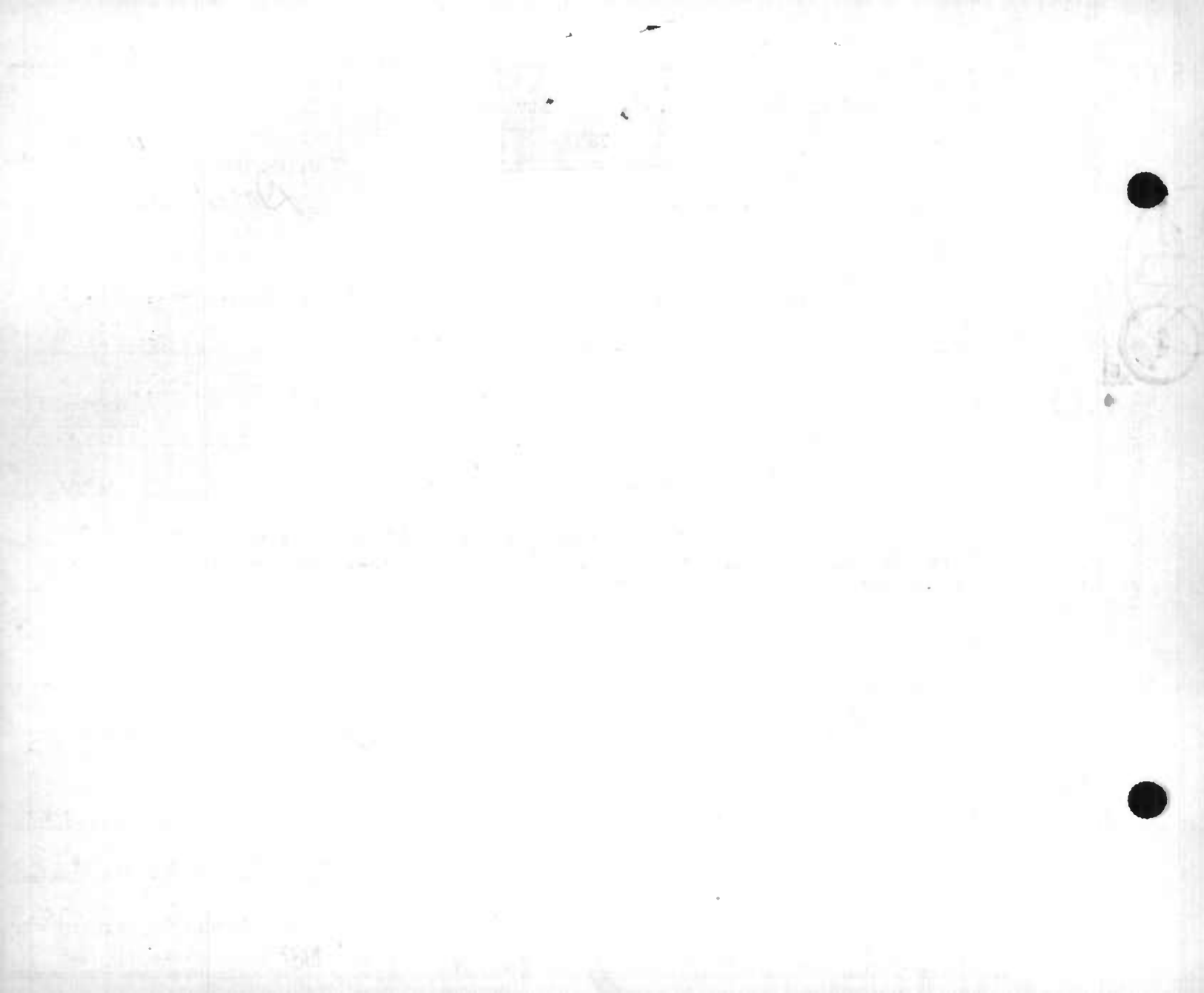
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 REG. NO. 360

| | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|--|--|--------------------------------------|--|---|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| Evelyn S. Stubbs | | | | | | | | MONTH DAY YEAR | | | | 19 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | 7d. HOUR | |
| Female | Black | MONTH DAY YEAR | | LAST BIRTHDAY YRS. | | MONTHS DAYS | | HOURS MIN. | | MONTH DAY YEAR | | | | 6 ⁰⁰ PM | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U. S. A. | | | | | | | | Dorchester MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cambridge | | 612 Greenwood Ave. (at home) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Dorchester | | Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 612 Greenwood Ave., Apt. 101 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Frank Haskins | | Florence Saunders | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 212 16 7702 | | Frances Wongus | | 616 North Drive Cambridge, Md., 21613 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | | | | | STAT | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | YEARS | | | |
| (b) ISCHEMIC HEART DISEASE | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | YEARS | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| IRON DEFICIENCY ANEMIA, 1 st AV BLOCK, MONOCLONAL GAMMOPATHY, DESCENDING THORACIC AORTIC ANEURYSM, AORTIC STENOSIS | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>James F. McCarter</i> | | | | TITLE (SPECIFY) M.D. DEPUTY | | | | DATE SIGNED 3-17-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JAMES F. MCCARTER, M.D. | | | | ADDRESS 424 AURORA ST. CAMBRIDGE, DORCHESTER, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Burial | | 3/21/87 | | Waugh Ceme | | | | Cambridge Por MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME ADDRESS STEWART FUNERAL HOME Cambridge Md. | | | | MAR 26 1987 | | | | <i>[Signature]</i> | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201-6600 OR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

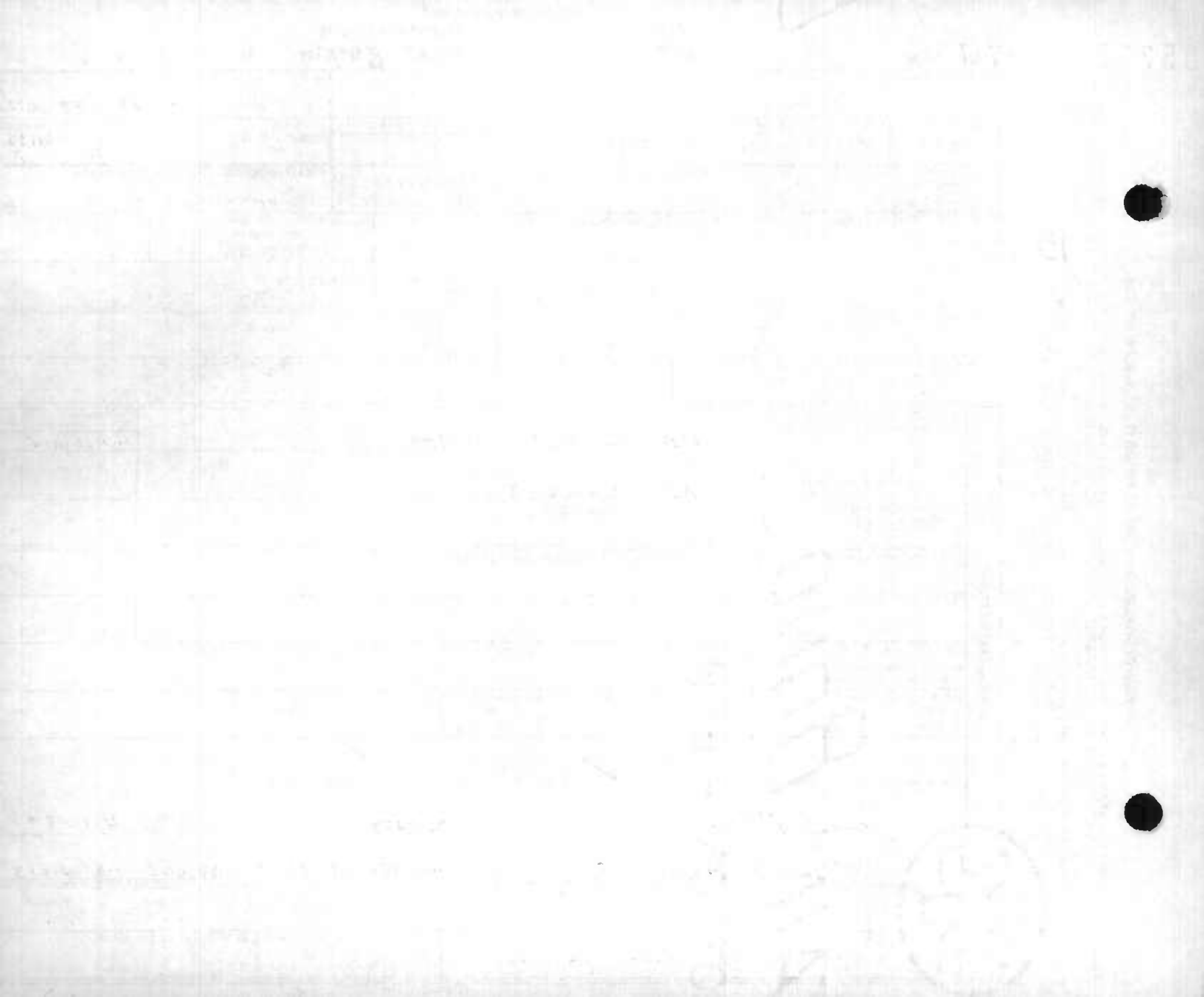
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD REMAIN WITHIN 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 361 | |
|---|--|------------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Otis McClain Todd | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 4 28 19 87 | | 2b. HOUR 0022 | | 2c. DATE OF DEATH MONTH DAY YEAR 19 87 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 26, 1918 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 68 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. | |
| 10. CITY OR TOWN OF DEATH Golden Hill | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 336 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Dorchester 13c. CITY OR TOWN Cambridge | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 410 Kent Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James T. Todd | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pency | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Vance L. Todd ADDRESS Rt 4 Box 269 A | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) MASSIVE HEAD INJURY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AUTO ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER | |
| ACTUAL SIGNATURE James F. McCarter | | | | M.D. DEPUTY | | | | DATE SIGNED 4-30-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JAMES F. MccARTER | | | | ADDRESS 400 AURORA ST. CAMBRIDGE, MD. 21613 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 4/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md. | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Frederick R. Sanders | | | |

MAY 6 1987



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 11362

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| WILLIE LURETTA VICKERS | | female | | white | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| Dec 31, 1903 | | 83 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MD. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Cambridge | | Dorchester General Hospital | | homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | |
| | | Md. | | Dor. | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 917 Roslyn Ave. 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Charles M. Todd | | Etha Todd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| NO | | 214-30-8474 | | Rt. 1 Box 57 | |
| | | | | J. Wendell Vickers Jr. Cambridge Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour YEARS 4 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 19 85 to 4/19, 19 87, that (b) (we) saw the deceased alive on 4/19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| MICHAEL A. MOSKEWICZ MD | | DEGREE | | 4/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| MICHAEL A. MOSKEWICZ MD | | 503 BAYEN ST. CAMBRIDGE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| burial | | 4/21/87 | | Dor. Mem. Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Cambridge Dor. Md. | | THOMAS FUNERAL HOME CAMBRIDGE MD, | | APR 23 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | J. Gordon-Randall | |

REEL 17 NOTION 6/20/64

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